
FINAL RECOMMENDATIONS FOR THE MEDICAL BOARD OF CALIFORNIA

Recommendations of the Department of Consumer Affairs and the Joint Legislative Sunset Review Committee (JLSRC)

ISSUE #1. (CONTINUE REGULATION OF THE PROFESSION AND THE BOARD?)

Should the licensing and regulation of physicians and surgeons be continued, and the professions be regulated by an independent medical board rather than by a bureau under the Department?

Recommendation #1: *Recommend that physicians and surgeons should continue to be regulated by the Medical Board of California in order to ensure public health and patient safety.*

Comments: The Medical Board of California (Board) was established in 1876 and is one of the oldest regulatory boards in the state. The Board's mission is to protect consumers through proper licensing of physicians and surgeons and other healing arts professionals through enforcement of the Medical Practice Act. The Board operates on an annual budget of approximately \$36 million and has a staff of almost 300 employees.

The nineteen-member board licenses over 100,000 physicians and surgeons and is responsible for licensing or registering approximately 4,000 affiliated healing arts professionals. The Board consists of twelve physicians and seven public members; seventeen appointed by the Governor and two appointed by the Legislature. Appointments are made to the Division of Licensing or the Division of Medical Quality.

In addition to physicians, the Board has jurisdiction over a variety of affiliated healing arts professionals. Currently, those licensed or registered by the Board are Licensed Midwives, Registered Dispensing Opticians (including Spectacle Lens and Contact Lens Dispensers) and Research Psychoanalysts, as well as regulating the scope of practice of unlicensed Medical Assistants.

The Board was last reviewed by the JLSRC and the Department in 1997-98. The Department continues to find the Board responsive to requests for information and recommended policies. The Board has assumed a leadership position on the Task Force on Culturally and Linguistically Competent Physicians and Dentists, and in Department discussions of consumer complaint disclosure. The Board has attended Department sponsored hearings and convened a committee of the Board, the Public Information Disclosure Committee, to discuss the issue and receive testimony from interested members of the public. The Board recently modified its historical position on public disclosure of information relating to consumer experience with physicians by agreeing to release summary information of malpractice settlements¹ that have been filed with the Board, redacting the patient's and plaintiff's names to protect their privacy.

¹ Malpractice lawsuits that have been resolved through the settlement process rather than by court judgment or arbitration.

Because consumers rely upon the oversight provided by the Medical Board to ensure that practicing physicians and surgeons are well trained and maintain a license in good standing, and because of the enormous responsibility physicians hold for ensuring public health and patient safety, the continued regulation of the profession is critical.

ISSUE #2: (REVIEW BARRIERS TO RESIDENCY AND LICENSURE FOR INTERNATIONAL MEDICAL GRADUATES?) Should the Board continue its involvement in issues related to physician shortages and providing health care for low-income consumers living in medically underserved areas?

Recommendation #2: The Board should designate a staff liaison to work with International Medical Graduates (IMGs) and programs that assist them.

Comments: The Board has established itself as a leader within the Department's regulatory culture. Beginning in 2001, the Board's Executive Officer has made significant contributions to the work of the Task Force on Culturally and Linguistically Competent Physicians and Dentists. As the Task Force examines issues pertaining to the need to increase access to health care for low-income consumers living in medically underserved areas, much of the discussion came back to questions about the licensure process for physicians and discussion of possible changes to that process. The participation of the Board's Executive Officer and the Board's advice in these discussions has been critical to Task Force deliberations and has been recognized by the members of the Task Force as key to thoughtful resolution of matters before the Task Force.

The Task Force has held five public hearings in communities throughout the State to assess consumers need for providers who are culturally and linguistically competent.² In each of these communities, the Task Force has heard from International Medical Graduates (IMGs) who wish to practice as physicians in the U.S. and have demonstrated competence by passing the United States Medical Licensing Examination (USMLE), but are unable to secure a residency position necessary for licensure. With the assistance of the Medical Board, the Task Force intends to look more closely at the barriers to residency and licensure encountered by IMGs. The Department recommends the Board designate a staff liaison to work with IMGs and the programs devoted to facilitating their licensure and re-entry into their profession. The Department commends the Board for its willingness to examine these issues and looks forward to continuing its collaborative work.

ISSUE #3: (CREATE PROGRAM FOR AFFILIATED HEALTH CARE PROFESSIONS?) Is it appropriate for the Board to continue regulating other health care professionals who are not physicians and surgeons or should these professions be regulated by another entity under the Department?

Recommendation #3: The feasibility of regulating affiliated healing arts professionals by another regulatory entity should be examined and an outside consultant should be retained to study the feasibility of establishing such an entity.

² San Diego, Salinas, Oxnard, San Francisco, Sacramento and Bell Gardens, California.

Comments: The Department concurred with the JLSRC's preliminary recommendation that the time has come to explore the feasibility of establishing a program for affiliated healing arts professionals, including licensed midwives, registered dispensing opticians and research psychoanalysts. Recognizing the limited resources of the Board, as well as the challenges associated with undertaking regulation of specialized professions, it is appropriate to consider moving non-physician licensees to another regulatory venue. The Department recommended that an outside consultant be retained to study the feasibility of establishing such an entity.

ISSUE #4: (STREAMLINE LICENSING REQUIREMENTS FOR STATE OR FEDERAL EMERGENCIES?) Could licensing and fee requirements be changed so physicians in retired or inactive status, or whose license has lapsed, could be utilized for state or federal emergencies?

Recommendation #4: *Streamline licensing and fee requirements for physicians and retired/inactive licenses, enabling them to practice in a state or federal emergency.*

Comments: The Board should allow physicians with lapsed licenses to request a retired license status without being required to pay the license fees plus delinquent fees for the years their license lapsed. Currently, when physicians retire, they are entitled to request that their license be retired, placing them in a fee exempt license category which allows them to continue to practice as long as they continue to fulfill the continuing education requirements.

Making this statutory change would enable retired physicians to reactivate their licenses quickly in the event of a physician shortage caused by a state or federal emergency. In light of recent events, the Board should streamline the process for retired physicians to return to practice if their skills are needed.

ISSUE #5: (CONTINUE EFFORTS TO DEAL WITH THE HIGH DISSATISFACTION BY COMPLAINANTS?) What should the Board do to deal with the high dissatisfaction rating it still receives by those who file complaints, even though the Board has made significant improvements in communicating with complainants?

Recommendation #5: *The Board should continue efforts to improve communication with consumers who file complaints with the Board. It should continue to assess consumer satisfaction with handling of complaints and provide quarterly progress reports to the Department over the next two years.*

Comments: As indicated by the Board, as part of its 1997 sunset review, a satisfaction survey was conducted by the Board as requested by the JLSRC. The results were alarmingly poor, showing that most of those filing complaints were highly dissatisfied with the outcome of their case (about 75%) and the overall service provided by the Board (about 60%). Since that time the Board has made some strides in attempting to maintain better communication with complainants and the recent survey seems to reflect that effort. About 80% of complainants are satisfied with the information and assistance they receive from staff of the Board, compared to about 53% in 1997, and about 53% are satisfied with the advice they receive on the handling of their complaint, compared to about 31% in 1997. However, there is still a high dissatisfaction with the outcome of their particular case, but improvements have been made. About 35% in 2000 were satisfied with overall service provided by the Board, as

compared to 24% in 1997.

The Department concurred with the JLSRC's preliminary recommendation that the Board should continue its ongoing effort to improve communication with consumers who file complaints with the Board. Although the Board's most recent satisfaction survey reflects improvement, the Board should continue to improve its communication with consumers about the status of complaints in a timely fashion.

The Department suggested the Board continue to assess consumer satisfaction with Board handling of complaints, and provide quarterly progress reports to the Department over the next two years. This will assist the Department in maintaining its oversight function of the Board.

It has been suggested that a Division of Enforcement Oversight should be established within the Department to ensure effective consumer complaint and discipline systems. This is an example of where such a Division within the Department could ensure that consumers are receiving a high level of responsiveness.

ISSUE #6: (AUTOMATICALLY REVOKE LICENSE OF PHYSICIAN WHO SEXUALLY ABUSED A PATIENT?) Should the license of a physicians be automatically revoked if they are found to have engage in any sexual exploitations of a patient?

Recommendation #6: *A physicians license should be subject to automatic revocation if found to have sexually abused, exploited or engaged in sexual contact with a patient and should not be subject to reconsideration by the Board.*

Comments: Business and Professions Code Section 729 subjects the licenses of psychologists, respiratory care practitioners and clinical social workers to automatic revocation if there is a finding of sexual abuse. This provision should be applied to physicians. Abuse of the patient/physician relationship is an egregious violation of trust and should have severe consequences. In the rare instance that a physician sexually abuses or exploits a patient under his or her care, the physician should lose the right to practice.

ISSUE #7: (COMPEL COMPETENCY EXAMINATION FOR DIVERSION PROGRAM PARTICIPANTS?) Should the Board be able to compel a competency examination for participants within its Diversion Program to assure they are current in medical practice skills and training?

Recommendation #7: *The Board should have the authority to require a competency examination of physicians participating in the Diversion Program.*

Comments: Physicians participating in the Board's diversion program for an extended length of time that have been out of touch with patients may not have the current clinical skills needed to return to practice. In order to guarantee that all licensees are providing a high standard of care to consumers, the Board should have the authority to require a competency examination before allowing the physician to return to practice.

ISSUE #8: (ENACT REGULATIONS TO CLARIFY PHYSICIAN SUPERVISION OF MIDWIVES?) Should the Board promulgate regulations to define and implement the requirement for physician supervision of licensed midwives consistent with recent interpretations of the practice of midwifery in California?

Recommendation #8: A midwifery model should be used in determining the standard of care for midwives and the appropriate level of physician supervision.

Comments: Since the passage of the Licensed Midwifery Practice Act in 1993, tension has existed between the physicians and the midwives, both of whom are licensed by the Board. The scope of practice of midwives authorizes them to attend home deliveries, practicing under the supervision of a physician. Unfortunately, due to liability concerns, no physicians are willing to provide the required supervision to a midwife. As a result, licensed midwives are disciplined by the Board when they attend a home birth regardless of the outcome of the birth. This action has had a chilling effect on licensed midwives and has reduced the number of practitioners available to women who choose to give birth at home.

To remedy this situation, the Department concurred with the JLSRC's preliminary recommendation that the Board should promulgate emergency regulations to clarify that in disciplinary proceedings a midwifery model of care, as defined in the Osborn decision³, rather than a medical model of care be used to determine the appropriate standard of care for midwives. Additionally, the Board should define in regulations the appropriate level of physician supervision that is necessary and consistent with the intent of the Licensed Midwifery Practicing Act. Pending this action by the Board, no further disciplinary action should be taken against midwives who lack physician supervision, absent evidence of other violations.

ISSUE #9: (APPOINT AN INDEPENDENT ENFORCEMENT MONITOR TO THE BOARD?) Should the Director of the Department appoint an independent enforcement program monitor to investigate and evaluate the Board's enforcement program?

Recommendation #9: *The Director of the Department should appoint an Enforcement Program Monitor, no later than July 1, 2003, whose duties would include monitoring and evaluating the Medical Board's disciplinary system and reporting his/her findings, as specified, to the Department and the Legislature every six months with a final report July 1, 2005. The Enforcement Program Monitor should be funded through the Contingent Fund of the Medical Board of California Fund.*

Comments: The Department concurred with the JLSRC preliminary recommendation that the Director of the Department should be authorized to appoint an enforcement program monitor to the Medical Board. The enforcement monitor is charged with investigating and evaluating the board's discipline system and procedures, making its highest priority the reform and reengineering of the board's enforcement program and operations. The Department has found that the use of an enforcement monitor at the Contractors' State License Board has been extremely effective in assisting the Board in improving the overall efficiency of the Board's disciplinary system.

³ Accusation against Alison Osborn, L.M. before the Division of Licensing, Medical Board of California. OAH No: N-1999040052

The size of the Medical Board combined with recent concerns raised by the alternative medicine community about the Board's enforcement program make the Board an ideal candidate for appointment of an enforcement program monitor. Additionally, the JLSRC has expressed concern about the length of the Board's disciplinary process, the amount of investigations and disciplinary actions taken by the Board, and the dissatisfaction consumers have expressed with the Board's handling of their complaints. The Department is not aware of any substantiated evidence that significant problems exist with the Board's enforcement program but feels that a review of the enforcement program by an independent monitor would address the concerns raised by the JLSRC and the alternative medicine community and would provide an overall benefit to the Board.

ADDITIONAL JOINT COMMITTEE RECOMMENDATIONS

ISSUE #10: (CONTINUE WITH REDESIGN OF THE LICENSING PROGRAM?) Should the Board continue its efforts to redesign its licensing program to deal with substantial delays that occurred in the licensing of physicians during the year 2001?

Recommendation #10: *The Board should continue to implement recommendations of the Cooperative Personnel Services (CPS) of Human Resource Services to redesign its licensing program.*

Comments: In 2001, substantial delays were encountered in the licensing of new physicians. The Board has recognized that there is a growing application workload that may result in further delays in the future if adjustments and improvements are not made to address it. To obtain an objective assessment of the Board's Licensing operations, and to solicit expert recommendations for remedies of the problems being experienced, in 2001, the Board contracted with CPS Human Resource Services. In June, after evaluating the processes of the program, as well as interviewing staff and managers, CPS made a number of observations and recommendations.

ISSUE #11: (IMPROVE LICENSING RECIPROCITY AND PORTABILITY?) Should the Board continue its efforts to improve on licensing reciprocity and portability for applicants from other states and countries?

Recommendation #11: *The Board should continue with its efforts to implement changes to enhance license portability and reciprocity for physician applicants from other states and countries and should be granted authority initially to waive clinical requirements for out-of-state applicants based on specified criteria.*

Comments: There are discussions which continue at the national level to explore mechanisms that could significantly improve the portability of state medical licensure, including licensure by endorsement and removing certain barriers to reciprocity between states in order to improve the ability of physicians to practice in other states. The Board continues to participate in those discussions and has been actively involved efforts to provide healthcare access to populations within California who traditionally experience either no care, or substandard medical care because of language or cultural barrier.

The Board has initially recommended changes to the strict clinical requirements for applicants from other states. As indicated by the Board, the specificity of the licensing law has created unintended delays for some qualified applicants who have practiced in other states, frequently, board-certified physicians, who trained many years ago when certain elements of their training differ from today's medical curriculum. The differences in their training is not substantial, and does not imply that they are not fully qualified to practice in California. Business & Professions Code Sections 2089.5 & 2089.7 not only requires adequate training in enumerated subjects, but specifies the actual amount of weeks of training in certain subjects. As an example, a board-certified neurosurgeon from Illinois, trained in the 1970s, may have trained five weeks in pediatrics and eight weeks in obstetrics and gynecology, which would be one week short of the six weeks required in pediatrics and two weeks over the required six weeks of OB/GYN. Under the current law, the Board has no discretion to certify that the applicant has substantially met the requirements for licensure, and the neurosurgeon would be forced to find a training program to provide the additional training in pediatrics. While there is certainly a good rationale for requiring the weeks of training outlined in most cases, in some, it is merely a unnecessary and unreasonable obstacle that delays the entry of qualified physicians to California.

It would appear reasonable and desirable to grant the Board's Division of Licensing the authority to determine the qualifications for licensure of those applicants who have maintained an unlimited and unrestricted license in another state for at least 10 years, but who lack a small measure of the existing clinical requirements.

ISSUE #12: (SHOULD POSTGRADUATE TRAINING BE INCREASED BY ONE YEAR?)
Should the current requirement for postgraduate training for U.S. graduates of medical school be increased from one year to two years?

Recommendation #12: *The Board should provide results of a study it is conducting to the JLSRC and the Department prior to any effort to increase postgraduate training by one year.*

Comments: One year of postgraduate training in an approved postgraduate training program is required for U.S. graduates and two years for international graduates. Nationally, there is some variability with many states requiring two or three years. The Federation of State Medical Boards has adopted a position that full licensure should be delayed until a third year of postgraduate training and urges all states to adopt this standard. During the last review, the JLSRC recommended that the Board not increase postgraduate study to two years because of lack of justification. The Board is currently involved in a study to determine if an additional year of postgraduate training should be required before licensure.

ISSUE #13: (CONTINUE WITH STUDIES AND PROJECTS TO IMPROVE QUALITY AND SAFETY OF HEALTHCARE FOR PATIENTS?) **Should the Board continue with its efforts to study and implement programs to improve the overall quality and safety of healthcare received by patients?**

Recommendation #13: *The Board should continue to: (1) implement the Practitioner Remediation to Enhance Patient Safety (PREPS) Project; (2) complete its study regarding physician discipline*

and its link to medical school professionalism problems; (3) continue its participation in the University of California program to develop patient safety models for its medical centers; and, (4) complete its study on risk factors for physicians discipline. It should also continue to participate in other programs, projects or studies that could potentially improve the overall quality and safety of healthcare for the public.

Comments: The Board has indicated that they are involved in several studies and projects to enhance the quality and safety of healthcare and to reduce medical errors and occurrence of patient harm.

ISSUE #14: (CHANGES TO THE BOARD'S CME PROGRAM?) Are changes needed to the Board's continuing medical education (CME) program?

Recommendation #14: *The Board should provide results of its study of the CME program and recommendations on any changes that are necessary to improve the overall quality of the program by March 2003.*

Comments: The requirement for CME is a long-standing feature of physician licensing. To ensure that physicians keep pace with the changing and complex field of medicine, the Board requires completion of an average of 25 hour of approved CME each year and a minimum of 100 hours every four years. A random audit of the licensee population is conducted each year to verify compliance with the CME requirement; those found not to be in compliance are subject to citations and fines. The Board indicated that it has made no changes in its CME program since its last sunset review, but indicates that is currently engaged in a study designed to determine if there are ways to enhance continued knowledge and competency of physicians.

ISSUE #15: (INCREASE PENALTY FOR UNLICENSED PRACTICE?) Should the penalty for practicing without a license be increased from a misdemeanor to a "wobbler" and impersonating a physician be a criminal sanction as recommended by the Board?

Recommendation #15: *Section 2052 of the Business and Professions Code should be changed to a "wobbler" (allowing the charging of a felony or misdemeanor) and impersonating a physician should be a criminal sanction.*

Comments: At present, practicing medicine without a license is a misdemeanor if there is no harm to the patient/victim. Section 2053 of the B&P Code allows for the charging of a felony if there is great bodily harm or potential for great bodily harm. The reality is that prosecutors will not charge a felony violation unless there is great bodily harm. For minor violations, a misdemeanor is appropriate. For more egregious violations, such as a recent case portrayed in "48 Hours," a felony would be more appropriate. (In this instance, the person posed and practiced as a doctor many times, and in one instance his lack of providing appropriate treatment resulted in the death of a patient. As a practical matter, changing Section 2052 to a "wobbler" would give the Board and prosecutors greater flexibility. The Board also indicated that impersonating a physician is not a crime. It is the opinion of the Board that there should be some criminal sanction for impersonating a physician.

ISSUE #16: (ALLOW FINANCIAL PENALTY FOR DISCIPLINARY CASES INVOLVING FRAUD?) Should a financial penalty be allowed when there is a finding of fraudulent activity on the part of the physician?

Recommendation #16: The Board should be granted authority to assess a financial penalty for disciplinary cases which involve fraudulent activity on the part of the physician.

Comments: As recommended by the Board, fine authority involving financial fraud should be utilized as part of the formal disciplinary action, and a part of the Board's current citation and fine program. Crimes included involve high stakes financial return from fraudulent activity, such as those surrounding insurance or worker's compensation fraud, selling fraudulent treatment or medicines to unsuspecting patients, of "fronting" for other practitioners involved in fraudulent practices. All of these activities, especially if severe, will likely result in severe disciplinary action, but under the current system, the perpetrator of the fraud may keep his or her ill-gotten profit. Allowing, through the administrative process, as explained by the Board, an assessment of a financial penalty two or three times the amount gained through fraudulent activity would appear just. (Especially in light of the reality that generally the amount of fraud discovered or the amount subject to prosecution is often less than the actual total of the gain.)

ISSUE #17: (ADOPT DISCIPLINARY POLICIES AND PROCEDURES REGARDING THE PRACTICE OF ALTERNATIVE MEDICINE?) Should the Board adopt disciplinary policies and procedures relating to the practice of alternative medicine and also assess the need for specific standards for investigations of those involved in alternative practice?

Recommendation #17: The Board should ensure that disciplinary policies and procedures are adopted to reflect alternative medical treatment and practices by July 1, 2002, and should provide the JLSRC with a copy of those policies and procedures, as well as with evidence of the discussion and assessment of the need for standards of investigation for those involved in the practice of alternative medicine, what recommendations were made, and what action the Board has taken pursuant to those recommendations.

Comments: In 2000, the Legislature passed SB 2100 (Vasconcellos, Chapter 660), the Alternative Medical Practices and Treatment Act. It required the Board to address the emergence of holistic health and consider whether steps should be taken to redesign their systems to meet the healthcare needs of those seeking alternative medical treatment. It also required the Board to establish disciplinary policies and procedures by July 1, 2002, to reflect emerging and innovative medical practices. To meet this mandate the Board formed an "Alternative Medicine Committee." The Board indicates that its Alternative Medicine Committee is considering some guidelines for practitioners wishing to use non-conventional methods of practice and disciplinary, and investigative guidelines for cases involving alternative medicine.

ISSUE #18 (FURTHER REFORMS NECESSARY TO THE DIVERSION PROGRAM?)

Should other changes and reforms be made to the current Diversion Program of the Board?

Recommendation #18: *The enforcement program monitor shall evaluate both the effectiveness and efficiency of the Board's current Diversion Program and make recommendations to the JLSRC and Department regarding the continuation of this program, and any changes or reforms which should be made to ensure that participants in the program are appropriately monitored, and to ensure protection of the public from physicians who are impaired due to abuse of alcohol or other drugs, or due to mental or physician illness.*

Comments: At the last sunset review, the Department and the JLSRC voiced concerns about the Board's Diversion Program which monitors licensees with substance abuse problems, and occasionally, mental illness. As indicated by the JLSRC, California appears to be one of only two state medical boards that operate its own diversion program. (With a total of about 10 states having any form of officially sanctioned diversion program.) The costs of California's diversion program has been steadily increasing, from \$786,000 in FY 1996/97 when last reviewed, to \$936,000 in FY 2000/01. There were about 273 active participants in the program as of June 30, 2001, and approximately 49 successful candidates in 1999/00. (Over the past eight years there has been about 35 successful candidates per year.)

Criticisms of the program included: (1) that it unreasonably diverts physicians from the Board's disciplinary process; (2) that it should not be operated by the Board, but instead by an entity in the private sector separated from the Board (reducing the licensees fear of disciplinary action thereby); (3) conflict of interest on the part of program staff (e.g., group counselors) who are paid \$235/mo. by participants (allegedly encouraging participant retention despite violations of the conditions of program participation); and, (4) the inability of the program to actually monitor a participating physician's compliance with agreed-to practice restrictions or cessation.

In response to the concerns of the JLSRC and Department, the Board formed a Diversion Task Force in February 1998, and undertook an extensive review of the operation of the Program. The issue of privatization of the Diversion Program was discussed and then rejected by the Committee. However, the Board indicated that a number of reforms were made to the current Diversion Program to ensure public protection. It is unclear at this time, however, whether the reforms of the Diversion Program have addressed all of the concerns raised by this committee during the last sunset review.

ISSUE #19: (CHANGE DISCLOSURE REQUIREMENTS AND IMPROVE

INFORMATION PROVIDED TO THE PUBLIC?) Should the Board provide more useful and meaningful information to the public regarding the Board and the licensees it regulates?

Recommendation #19: *By January 1, 2004, the Board shall promulgate regulations to provide more useful and meaningful information to the public regarding the Board and the licensees it regulates.*

Comments: From August to October 1999, and subsequently in January 2000, the Public Citizen's Health Research Group (HRG) surveyed 51 boards that regulate medical doctors to determine what type of information was made available to the public over the Internet. In what format is it presented?

How complete and current is it? How does it compare to the disciplinary information a consumer can get by calling the board? The HRG created a grading scale to assess the adequacy of information provided over each of the web sites it reviewed. Out of a possible A to F grade, the California Medical Board received a grade of “D.”

California’s near failing grade, and the related facts that other states disclose more, has raised serious questions regarding why the Board does not disclose more of what it knows about physicians to the public. There have also been questions raised about how soon in the disciplinary process information should be made available to the public, and if reportable information to the Board, such as malpractice settlements, should also be disclosed to the public.

The Board indicates that it has established a “Committee on Public Information Disclosure” to discuss the issues surrounding the information it provides to consumers, how it might be made more meaningful to consumers, and what modifications should be made to current law or policy.